INTERNATIONAL RESCUE COMMITTEE
SIERRA LEONE PROGRAM

QUARTERLY REPORT

INFECTION PREVENTION AND CONTROL (IPC) AND SCREENING FOR SUSPECTED EBOLA PATIENTS IN PRIMARY HEALTH CARE FACILITIES IN SIERRA LEONE

(CONTRACT NO: AID-OFDA-G-15-00025)

JANUARY 1, 2015 – MARCH 31, 2015

PRESENTED TO:

THE USAID OFFICE OF FOREIGN DISASTER ASSISTANCE

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I. Executive Summary

PROGRAM TITLE:	Infection Prevention and Control (IPC) and Screening for Suspected Ebola Patients in Primary Health Care Facilities in Sierra Leone
PROJECT NO:	AID-OFDA-G-15-00025
AGENCY:	International Rescue Committee (IRC)
COUNTRY:	Sierra Leone
CAUSE:	Ebola Virus Disease Outbreak
REPORTING PERIOD:	January 1, 2015 – March 31, 2015
GOAL:	Ensure that Sierra Leoneans are able to access health services from trained and protected health workers in all Peripheral Health Units (PHUs) within the context of the Ebola outbreak.
OBJECTIVES:	Health: Enable PHU s to remain open, accessible, and providing care, by ensuring screening processes are in place, IPC protocols are followed, and that isolation of suspected Ebola cases occurs.
BENEFICIARIES:	Total targeted: 6,696 (3,729 Health care workers; 2,976 CHWs) Direct; 5,883,302 Indirect IDP beneficiaries: N/A
LOCATION:	All districts of Sierra Leone except for Koinadugu
DURATION:	7.5 Months

Introduction

In August 2014, the International Rescue Committee (IRC) initiated the creation of the Ebola Response Consortium (ERC) to support the Ministry of Health and Sanitation (MoHS) in Ebola response through a coordinated approach from non-governmental organizations (NGOs). The full ERC is now comprised of eight member organizations – Action Contre la Faim (ACF), CARE International, Concern Worldwide, GOAL, King's Health Partners, the IRC, Marie Stopes Sierra Leone and Save the Children – and four partner organizations – ABC Development, eHealth, Muloma Women's Development Association (MUWODA), and Welbodi Partnership - who have pooled their collective technical and operational resources to support the MoHS in the fight against Ebola. The ERC is currently supporting three key initiatives within the response: 1) support of a national strategy for Infection Prevention and Control (IPC) and screening of suspected Ebola Virus Disease (EVD) cases at 1,096 Peripheral Health Units (PHUs) and 20 government hospitals in the country, 2) support for effective surveillance in 10 districts of the country, and 3) continuation of primary health care in 5 districts.

An outbreak of EVD was initially identified in Guinea in March 2014, and since has spread to Liberia, Mali, Nigeria, and Sierra Leone. The Sierra Leone MoHS on May 26, 2014 declared an outbreak in Sierra Leone. As of early March 2015, 60-100 cases per week were still being reported until numbers began to decline later in the month. Through March 31, 2015, the MoHS reported 11,993 confirmed, suspected, and probable cases of Ebola, and 3,804 confirmed, suspected, and probable deaths caused by Ebola for all of Sierra Leone's 14 districts.

Patients with EVD are still presenting to non-EVD facilities, continuing to pose a significant risk of transmission to healthcare workers (HCW), facility staff, other patients and visitors. Since the start of the outbreak, over 400 HCWs have become infected with EVD, leading to fear among HCWs and patients, resulting in reduced availability and utilization of routine essential health services. Maintaining IPC precautions, instituting strict screening and isolation procedures, and determining appropriate modifications for routine services are essential measures for ensuring the safety of the healthcare work force. The ERC is currently implementing a scale up of IPC mentoring and supervision for all PHUs in the country (with exception of Koinadugu district) funded by OFDA. The ERC has developed a strategy to reinforce the fundamental IPC approaches in line with initial assessments made of each PHU. Ongoing supportive supervision and on-the-job training based on identified areas of weakness of health worker IPC and screening practices will ensure health workers at PHUs feel confident in continuing to safely provide health care to their communities, and will also be able to take necessary steps to immediately correct any mistakes as they are identified. Health facilities that demonstrate weak IPC practices will receive additional support according to need, until they have improved IPC and screening practices.

II. Summary of Activities

Sierra Leone

Type of Disaster: Pandemic Disease
Total Number of Beneficiaries: 6,696 Direct; 5,883,302 Indirect
Intervention Month(s): November 15, 2014 to June 30, 2015

Within this reporting period, IRC and its partners carried out the following activities.

Health Systems and Clinical Support

Trainings at PHUs/Establishing Screeners

During the reporting period, ERC partners signed Memorandums of Understanding with District Medical Officers in all districts of Sierra Leone, outlining the core responsibilities and activities in the implementation of IPC mentoring at the PHU level. To enable sufficient capacity for EVD screening, ERC partners trained staff at 1,103 PHUs, and ensured that screening stations were established at PHUs and that dedicated staff were actively screening

everyone who enters the facility. Staff trained at PHUs to carry out screenings included clinical, CHWs, traditional birth attendants (TBA) and support staff for a total number trained in all districts of 7,062. Of that total, 2,800 CHWs were trained to be screeners. These CHWs were selected by the PHU in-charge in respect with these criteria: 1.) CHW is currently working at PHU as volunteer; 2.) CHW is able to write and read; 3.) CHW resides near the PHU and; 4.) CHW agrees to be available each day to conduct the screening at the PHU. People who were working for an NGO or on surveillance activities were not selected to be trained. CHWs were provided with a monthly incentive for work in the reporting period at the nationally-approved rate. The deployment of these screeners contributed towards reducing the workload on the limited PHU staff.

ERC clinical staff have continuously mentored and supervised the CHWs as part of the routine IPC supportive supervision visits. There have been improvements in the screening process across the districts. Gains made from this training improved PHUs' work in identifying, isolating and referral of suspected EVD cases. Supported PHUs are better able to carry out proper screening and to safety isolate a suspected EVD if they present at the PHU.

Distribution of IPC Supplies

In parallel with training provided, ERC partners facilitated distributions of UNICEF-provided PPE and IPC materials to all the PHUs in November 2014 and resupply in February/ March 2015. These supplies, which included gloves, chlorine, goggles, boots, aprons, face masks, gowns and waste bags, were received and distributed to 1,103 PHUs. In addition, facilities were supported with visual aids, such as Posters of Hand Washing, Putting On and Off PPEs, and Ebola screening charts, all of which are placed in strategic locations in the health facilities to support the PHUs in keeping updated on the training that were provided by ERC. To aid in the proper setting up of screening and isolation stations at PHUs, ERC partners procured and delivered chairs, tables, tarpaulins, and batteries for electronic thermometers to PHUs based on need. ERC partners used the monthly quality assurance assessment to follow up shortages of supplies for timely restocking through district coordination meetings on a quarterly basis.

Follow up Supervisions

Following the initial trainings, the ERC training teams have commenced bi-monthly mentoring and supervision sessions during which they also complete the quality assessment tool to monitor the progress of the staff and the facility against the ideals for IPC practice and structure. Hands-on supportive supervision is provided during these visits. Low performing teams were strengthened by addressing their weak areas through refresher on the-job-training. A total of 4,070 supervision visits to PHUs were completed during the reporting period with approximately 24% of these visits being jointly conducted with the District Health Management Team (DHMT). These visits enable the DHMT to identify IPC gaps, which can inform district health programming decisions and improved IPC supervision strategies, while simultaneously reinforcing to health workers that strengthening IPC is an important long-term priority of the government.

The assessments done as a part of the follow up supervisions have shown facilities and staff making steady improvements. The percentage of clinics requiring urgent action for IPC structure has decreased from a baseline of 88% to 26% by March 31, 2015. IPC practices have also improved as the percentage of PHUs requiring urgent action on IPC practice based on the assessment scores have decreased from baseline figures of 74% to 30%.

Adherence to IPC Practices

As the caseloads began to decrease in late January, motivation at the PHU to adhere to IPC practices was more challenging. ERC partners counteracted this through resupplying PHUs with materials for screening stations, regular mentoring and support and training on usage of SMART phones to collect data, developing criteria for awarding PHUs who maintained high standards in IPC and presenting District Trainers with Certificates of achievements in the targeted districts.

Community Health Education/Behavior Change

Community engagement has been an important complement to the IPC work at health facilities. ERC partners have supported meetings with the Facility Management Committee (FMC) at targeted health facilities to sensitize communities about the IPC measures established at the health facility and explain the rationale for improved IPC. Through the FMC meetings, ERC partners mobilize community members to seek healthcare and attend health facilities for both preventive and curative health services, emphasizing that the robust IPC measures in place will help ensure protection of patients and health workers from cross-infection from EVD or other infectious diseases. Through the FMC meetings, dialogue highlights key issues hindering IPC activities. For example, people still fear coming to the health facilities, and in this case FMC members work to help communities understand that health personnel are well trained to handle cases and they should not be afraid to seek care. FMC members act as a liaison between the health facility and the community and committee members go out to the catchment communities to encourage community members to attend the health facility when they are ill. The FMC also work to mobilize pregnant and lactating women (PLW) and community members to attend the health facilities.

III. Indicator Tracking

Table 2: Objective Achievements for Project by Indicator

Indicator	Unit	Target	Actual Q2		Cumulative		Remark
Health: Health Systems and Clinical Support							
Number of health care facilities supported[1] and/or rehabilitated by type (e.g., primary, secondary, tertiary)	Facility	1096	1,103		1,103		
Number of health care providers trained by type (doctor, nurse, community health worker, midwife and traditional birth attendant) disaggregated by sex[2]	Person	6,696	4,264		4,264		
Number of consultations, disaggregated by sex and age[3]	Person	TBD	M	F	M	F	
Under-five			176,744	187,291	176,744	187,291	
Over-five			133,622	182,915	133,622	182,915	
Number and percentage of PHUs per month that require "urgent action" (retraining, etc.) in their Ebola response in terms of their (a) infection prevention and control structure; or (b) infection prevention and control behavior[4]	Facility	25%	a) 26% (n=262) b) 30% (n=307)		a) 26% b) 30%		
Health: Community Health Education/Behavior Change							
Number of CHWs trained[5] and supported (total and per 10,000	Person	3,288	2,800		2,800		

[1] "Support" in this case means setting up screenings at all of the health facilities.
[2] This training will be rapid training at the PHU level and supervision.
[3] The ERC will not be able to disaggregate this information to the level of detail normally needed (0-11 months; 1-4 years; 5-14 years; 15-49 years; 50-60 years; 60+ years) as part of this project. The ERC will disaggregate only by under-five and over-five, as well as by sex. Further disaggregation would add a layer of data compilation that would be unfeasible with this number of health facilities.
[4] The ERC will also monitor key inventory at each PHU but our partner UNICEF is responsible for stocking and restocking (the ERC will distribute inventory items at each PHU once they are received at district level from UNICEF).
[5] The CHWs/TBAs will be trained to do screening at PHU

Table 2: Objective Achievements for Project by Indicator

Indicator	Unit	Target	Actual Q2	Cumulative	Remark
population within project area), disaggregated by sex					
Number and percentage of CHWs specifically engaged in public health surveillance[6]	Person	3,288; 100%	2,694, 82%	2,694	

IV. Constraints and challenges

PPE Supplies
Incomplete supplies alongside inaccurate distribution of supplies resulted in stock out of PPE supplies at some facilities. In addition, in some PHUs, staff quickly consumed many of the supplies especially gowns, aprons and gumboots at the early stages, local PHUs have had to redistribute supplies between smaller and larger facilities.

Adherence to IPC protocols
Despite regular mentoring sessions by District Trainers, the PHU staff in many facilities still struggled to adhere to IPC protocols. Even facilities which had regular suspected cases attending the facility struggled to attain quality screening. In some cases, CHOs and In-Charges of health facilities failed to prioritize the screening station as critical to ensuring safety and proper screening. In many facilities a security guard or volunteer would often be found at the screening station prior to training CHWs as screeners. Over the course of 3 months' constant mentoring this practice has gradually improved.

PHU infrastructure
Waste management remains an issue with many PHUs having poor access to water supplies or are located in tight urban areas which hinders their ability to construct separate waste pits or VIPs. Space often restricted PHUs ability to develop a separate isolation space. Other facilities were creative in their use of trees, verandas and small green spaces. In regards to screening, a major challenge is creating a barrier for entry into the PHUs. It is uncommon to find a PHU with a fence/barrier. The rainy season is approaching and a foreseen challenge is the destruction of the temporal structures constructed for screening and isolation. Most of the structures are not water proof and are very likely to be affected during the raining season.

Community support
A number of communities had a serious misunderstanding of what a PHU's isolation space is or expressed concern over duration of someone being held in a facility. Hence, meetings with community structures and PHU staff were required for community members to engage in dialogue and understanding of what was required and garner their support. In some districts it was difficult to get the community to buy into assisting the PHU with IPC structures, particularly regarding building fences for PHU and isolation facility, latrines or burning pits. Many communities have asked for incentives if they are to work at the PHU instead of working during farming season. In addition, communities' confidence in PHUs has not fully returned – some stigma for PHUs which have been associated with Ebola. This lack of acceptance is even seen with the screening areas, as presence of a screening area with a screener wearing PPE is taken to mean that there is something wrong in their communities. The screening activities are now better understood through community education.

Coordination
Earlier in the reporting period it was challenging to undertake joint supervisions with the DHMT, due to the many competing priorities facing the DHMT in the Ebola response. The lack of visits by DHMT creates issues around

[6] This engagement refers to screenings conducted by CHWs/TBAs

ownership, sustainability and effectiveness as PHU staff are more likely to improve performance when instruction comes from direct line managers. Screener retention is an anticipated constraint in the next quarter, as some of the trained screeners are teachers/students who will soon return to school.

V. Activities for the following quarter

Planned activities for the next quarter include on-going twice-monthly supportive supervision visits to each PHU to monitor and strengthen IPC practices, as well as quarterly visits with the DHMT. Performance based awards will be provided monthly to the top 10 PHUs in each district; it is hoped that this will improve quality and performance. District team meetings will also be established to review program data and prioritize PHUs for support and action. Screening stations, IPC and PPE supplies will be distributed on an as needed basis to PHUs. Payment of incentives to screeners and community meetings with Health Management Committees will be continue for targeted facilities.

The ERC is also working with MoHS, UNICEF, CDC and WHO to develop a comprehensive plan for the next phase of the IPC in PHU project that will start in July 2015. This plan will be aligned with the Government of Sierra Leone (GoSL) Health Sector Recovery Plan.